| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155764 | A. BUILDING 00<br>B. WING | 08/24/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SPRING MILL HEALTH CAMPUS | 101 W 87TH AVE<br>MERRILLVILLE, IN46410 |

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| F0000 | This visit was for the Investigation of Complaint IN00094788.<br><br>Complaint Number: IN0094788 substantiated, Federal/state deficiencies related to the allegations are cited at F 157, F 225, F 226, F 323, and F 514.<br><br>Survey Dates: August 19, 22, and 24, 2011.<br><br>Facility Number: 010739<br>Provider Number: 155764<br>Aim Number: N/A<br><br>Survey Team:<br>Marcia Mital, RN, TC<br><br>Census Bed Type:<br>SNF: 38<br>Residential: 65<br>Total: 103<br><br>Census Payor Type:<br>Medicare: 32<br>Other: 71<br>Total: 103<br><br>Sample: 4<br>Residential Sample: 3<br><br>These deficiencies reflect state findings | F0000 | The submission of this Plan of Correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herin are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirments of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | cited in accordance with 410 IAC 16.2<br><br>Quality review completed on August 29, 2011 by Bev Faulkner, RN | | | |
| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br>Based on record review and interview, the | F0157 | 1. Resident B's physician and | 09/23/2011 |

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| | facility failed to ensure a resident's physician and family member were notified of a skin tear in a timely manner for 1 of 4 residents reviewed for physician and family notification in a total sample of 4. (Resident B)<br><br>Findings include:<br><br>Resident B's record was reviewed on 8/19/11 at 12:45 p.m. Resident B's diagnoses included, but were not limited to, dementia, hypertension and anemia.<br><br>A "skin impairment circumstance..." form, dated 7/16/11, indicated the resident had a skin tear to the right forearm. There was a lack of documentation on the form to indicate the resident's physician or family had been notified of the skin tear.<br><br>The resident's nurses' notes, lacked documentation of an entry for 7/16/11.<br><br>A physician's order, dated 7/18/11, indicated "Apply bacitracin to S.T. (skin tear) on R (right) FA (forearm) et (and) cover c (with) dry dressing dly (daily)."<br><br>During an interview on 8/19/11 at 1:45 p.m., LPN #1 indicated the physician was not notified of the skin tear for two days. LPN #1 indicated when he came into work on 7/18/11 he called the physician | | family were notified. There was no negative outcome noted.2. Current residents with changes, injuries, etc. are at risk for alleged deficiency. Current residents with change of conditions, injuries and/or circumstance forms will be reviewed by DHS or designee for physician and family notification. Notification will be made accordingly for any incidents identified to be out of compliance.3. DHS or designee will in-service nurses on physician and family notification per facility policy.4. Change of condition, circumstance forms and injuries, etc. will be reviewed daily for timely notification. Trends will be brought to QA for 6 months or until 100% compliance is achieved.5. 9/23/11 | |

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| | for a treatment order. LPN #1 indicated he was unable to find anything which indicated the family had been notified of the skin tear.<br><br>A facility policy, dated 11/08/10, titled "Guidelines For Responsible Party Notification", received from the administrator as current, indicated "...The responsible party should be notified of change in condition...in a timely manner..Documentation of notification or notification attempts should be recorded in the resident's medical record..."<br><br>This federal tag relates to Complaint IN00094788.<br><br>3.1-5(a)(1) | | | |

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| F0225 SS=D | The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | | | |
| | Based on observation, record review, and interview, the facility failed to complete an investigation for injuries of unknown origin and failed to notify ISDH (Indiana State Department of Health) of the | F0225 | 1. Facility completed investigation on Resident B and notified ISDH (Indiana State Department of Health) at the time of survey. There was no negative outcome noted.2. All residents are at risk | 09/23/2011 |

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| | injuries for 1 of 4 residents reviewed for injuries of unknown origin in a total sample of 4. (Resident B)<br><br>Findings include:<br><br>Resident B's record was reviewed on 8/19/11 at 12:45 p.m. Resident B's diagnoses included, but were not limited to, dementia, hypertension and anemia.<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 8/5/11, indicated the resident had severe cognitive impairment.<br><br>An accident/incident report, dated 8/16/11 at 7:00 a.m., indicated "...the resident was found with bruising to nose, sides of mouth, lip tear...Describe Injury...skin tear and bruise small in size (indicated by being circled)...Additional Information Resident was seen with redness to nose tip, both sides of mouth and lip with skin tear very agitated." The Incident/Accident investigation was left blank.<br><br>Resident B was observed on initial tour with LPN #1 on 8/19/11 at 8:50 a.m., sitting in his wheelchair in the dining room. There was a scabbed area to the resident's lower lip on the left side and a bruise that was yellow in color to the resident's face next to his mouth. The tip of the resident's nose was brownish red in | | for alleged deficiency. Investigations for incidents of unknown origin will be reviewed for thoroughness and appropriate notification to ISDH (Indiana State Deparment of Health) by DHS or designee. Additional investigating or reporting will be completed accordingly.3. DHS or designee will in-service nurses on investigation procedures per facility policy and state reportable guidelines. Nurses will be required to notify Administrator or designee of situations requiring an incident report. 4. DHS or designee will review investigations within 24 hours of the incident and report to ISDH accordingly. Trends will be brought to monthly QA x 6 months or until 100% compliance is achieved.5. 9/23/11 | |

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| | color. LPN #1 indicated the resident had bitten his lip and the yellow bruise to the resident's face was new.<br><br>A "Change in Condition Form" dated 8/16/11, indicated "...7:15 a...Resident was seen with tip of nose reddish/bruised both sides of mouth with red marks, lip reddish skin tear and extremely aggitated (sic)..." The follow up assessments for 8/16/11 the 3-11 shift and 8/16/11 the 11-7 shift were blank and lacked assessments. The last documentation of an assessment was dated 8/18/11 on the 7-3 shift. There was a lack of documentation of an assessment for the 11-7 shift on 8/17/11 and the 3-11 and 11-7 shifts on 8/18/11.<br><br>During an interview on 8/19/11 at 1:24 p.m., RN #2 indicated an investigation was supposed to be done by the nurse on 8/16/11 when the injuries were found. She indicated she had seen the yellow bruise on the resident's face when she had worked on Wednesday 8/17/11. She indicated the resident's son had come in on Wednesday and asked what happened.<br><br>During an interview on 8/19/11 at 1:55 p.m., the Director of Nurses (DON) indicated she would have to check with LPN #1 for the investigation. She indicated the investigation should have | | | |

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| | been on the incident report. The DON indicated the areas should have been reported to ISDH and an investigation started because of where the areas were located.<br><br>Resident B was observed on 8/19/11 at 2:10 p.m., with LPN #1 present. LPN #1 measured the areas to the resident's lip, nose, and bruise to left side of face by his mouth. The area to the resident's nose was 1.8 centimeters by 1.7 centimeters and was reddish/brown in color. The resident's left cheek bruise measured 4.6 by 1.7 centimeters and was yellow/green color. The resident's left lower lip scab was 3.2 by 0.2 centimeters. LPN #1 indicated he had started the investigation of how the areas occurred, but he had documented in a note book and he was unable to find the note book.<br><br>This federal tag relates to Complaint IN00094788.<br><br>3.1-28(d) | | | |

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| F0226 SS=D | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on observation, record review, and interview, the facility failed to follow their policy for investigating injuries of unknown origin and failed to notify ISDH (Indiana State Department of Health) of the injuries for 1 of 4 residents reviewed for injuries of unknown origin in a total sample of 4. (Resident B)<br><br>Findings include:<br><br>Resident B's record was reviewed on 8/19/11 at 12:45 p.m. Resident B's diagnoses included, but were not limited to, dementia, hypertension and anemia.<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 8/5/11, indicated the resident had severe cognitive impairment.<br><br>An accident/incident report, dated 8/16/11 at 7:00 a.m., indicated "...the resident was found with bruising to nose, sides of mouth, lip tear...Describe Injury...skin tear and bruise small in size (indicated by being circled)...Additional Information Resident was seen with redness to nose tip, both sides of mouth and lip with skin tear very agitated." The Incident/Accident investigation was left blank. | F0226 | 1. Facility completed investigation on Resident B and notified ISDH at the time of survey. There was no negative outcome noted. 2. All residents are at risk for alleged deficiency. Investigations for incidents of unknown origin will be reviewed for thoroughness and appropriate notification to ISDH by DHS or designee. Additional investigating and/or reporting will be completed accordingly.3. DHS or designee will in-service nurses on investigation procedures per facility policy and state reportable guidelines. Nurses will be required to notify the Administrator or designee of situations requiring an incident report.4. DHS or designee will review investigations within 24 hours of the incident and report to ISDH accordingly. Trends will be brought to monthly QA x 6 months or until 100% compliance is achieved. 5. 9/23/11 | 09/23/2011 |

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Resident B was observed on initial tour with LPN #1 on 8/19/11 at 8:50 a.m., sitting in his wheelchair in the dining room. There was a scabbed area to the resident's lower lip on the left side and a bruise that was yellow in color to the resident's face next to his mouth. The tip of the resident's nose was brownish red in color. LPN #1 indicated the resident had bitten his lip and the yellow bruise to the resident's face was new.

A "Change in Condition Form," dated 8/16/11, indicated "...7:15 a...Resident was seen with tip of nose reddish/bruised both sides of mouth with red marks, lip reddish skin tear and extremely aggitated (sic)..." The follow up assessments for 8/16/11 the 3-11 shift and 8/16/11 the 11-7 shift were blank and lacked assessments. The last documentation of an assessment was dated 8/18/11 on the 7-3 shift. There was a lack of documentation of an assessment for the 11-7 shift on 8/17/11 and the 3-11 and 11-7 shifts on 8/18/11.

During an interview on 8/19/11 at 1:24 p.m., RN #2 indicated an investigation was supposed to be done by the nurse on 8/16/11 when the injuries were found. She indicated she had seen the yellow bruise on the resident's face when she had

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| | worked on Wednesday 8/17/11. She indicated the resident's son had come in on Wednesday and asked what happened.<br><br>During an interview on 8/19/11 at 1:55 p.m., the Director of Nurses (DON) indicated she would have to check with LPN #1 for the investigation. She indicated the investigation should have been on the incident report. The DON indicated the areas should have been reported to ISDH and an investigation started because of where the areas were located.<br><br>Resident B was observed on 8/19/11 at 2:10 p.m., with LPN #1 present. LPN #1 measured the areas to the resident's lip, nose, and bruise to left side of face by his mouth. The area to the resident's nose was 1.8 centimeters by 1.7 centimeters and was reddish/brown in color. The resident's left cheek bruise measured 4.6 by 1.7 centimeters and was yellow/green color. The resident's left lower lip scab was 3.2 by 0.2 centimeters.<br><br>An undated facility policy, titled "Abuse and Neglect Procedural Guidelines", received from the Administrator on 8/33/11 at 12 p.m., as current, indicated "...The Executive<br>Director of Health Services are responsible for the implementation and | | | |

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| | ongoing monitoring of abuse standards and procedures...Injuries of unknown source- means an injury that occurs when both of the following conditions are met: i. The source of the injury is not observed by any person or the source of the injury could not be explained by the resident AND ii. The injury is suspicious in nature because of the extent of the injury or the location of the injury...the injury is located in an area not generally vulnerable to trauma...The Executive Director is responsible for...Notification to the State Department of Health...Investigation...the Executive director is accountable for investigating and reporting..."<br><br>This federal tag relates to Complaint IN00094788.<br><br>3.1-28(a) | | | |
| F0323<br>SS=D | The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on record review and interview, the facility failed to ensure interventions were put into place to prevent further falls for 2 of 3 residents with falls in a total sample | F0323 | 1. Residents D and E were no longer at skilled facility at the time of this deficiency. There were no negative outcomes noted.2. All residents at risk for falls are at risk for alleged deficiency. All | 09/23/2011 |

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| | of 4. (Residents D and E)<br><br>Findings include:<br><br>1. Resident D's record was reviewed on 8/22/11 at 9 a.m. Resident D's diagnoses included, but were not limited to, dementia, cervical spine fracture, and pneumonia.<br><br>An admission MDS (Minimum Data Set) assessment, dated 6/12/11, indicated the resident had severe cognitive impairment, required extensive assistance of one to two staff members for transfers and toilet use. The resident was frequently incontinent of bowel and bladder and was not on a toileting program.<br><br>A care plan, dated 6/3/11, indicated "Incontinence...Check and change with rounds and PRN (as needed)...Wear incontinence product at all times...."<br><br>A care plan, dated 6/3/11, indicated "Falls at risk for fall/injury AEB (as evidenced by) history of falls....low bed position. Half rails as enabler...Appropriate footwear...6/17/11 bed alarm...6/29/11 bolster mattress...7/5/11 sleep circumstance..."<br><br>A nurses' note, dated 6/29/11 at 9:15 p.m., indicated "RN finds patient on floor next | | current residents identified as fall risks will have interventions reviewed for effectiveness by DHS or designee. Interventions will be updated accordingly.3. DHS or designee will in-service nurses on interventions to prevent further falls per facility policy.4. All residents will be assessed for fall risk upon admission. Nurses will report to on-call nurse or designee any resident who falls and appropriate intervention will be put in place. Incident reports will be reviewed by DHS or designee as they are completed for appropriate interventions. Indicent report trends will be reviewed monthly in QA meeting.5. 9/23/11 | |

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|---|---|---|---|
| | 155764 | A. BUILDING 00<br>B. WING | 08/24/2011 |

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| SPRING MILL HEALTH CAMPUS | 101 W 87TH AVE<br>MERRILLVILLE, IN46410 |

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| | to bed and incontinent of stool. 4 cm (centimeters) x (by) 1.5 cm hematoma to R (right) elbow noted...patient assisted back to bed c (with) two assist..."<br><br>A fall circumstance, assessment and intervention form, dated 6/29/11, indicated the new intervention put into place for the resident's fall was defined parameter mattress. There was a lack of documentation to indicate any new interventions related to the resident's incontinence.<br><br>The resident's fall care plan, dated, 6/3/11, indicated the new intervention of a bolster mattress had been added on 6/29/11.<br><br>A fall circumstance, assessment and intervention form, dated 7/5/11, indicated the resident had been found on the floor of the resident's room in the bathroom doorway. The resident had an abrasion to the left side of his forehead. The activity at the time of the fall was "transferring self", "toileting" and "ambulation." The form indicated the "prevention update" was "sleep circumstance." There was a lack of documentation to indicate the resident's attempt to toilet himself had been addressed.<br><br>During an interview on 8/22/11 at 9:36 a.m., the ADON (Assistant Director of | | | |

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| | Nurses) indicated a "Sleep Circumstance" form would not help if the resident had to use the restroom.<br><br>2. Resident E's record was reviewed on 8/22/11 at 11 a.m. Resident E's diagnoses included, but were not limited to, diabetes mellitus, hypertension, stroke, and aphasia.<br><br>An admission MDS assessment, dated 5/19/11, indicated the resident had severe cognitive impairment, required extensive assistance of one staff member for transfers and toilet use. The resident had fallen since admission to the facility.<br><br>The care area assessment, dated 5/25/11, for falls indicated the resident had a fall since admission. The resident needed extensive assistance with ADLS (Activities of daily living) had a stroke and hemiparesis. The resident's risk factors were that the resident took antidepressant, high blood pressure, and hypnotic medications, and had cognitive deficits that affected his safety and judgement. The facility was proceeding to care plan.<br><br>A care plan, dated 5/15/11, indicated "Falls at risk for fall/injury AEB history of falls...interventions...other break (sic) extenders...educate /remind resident to | | | |

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| | request assistance prior to ambulation. Appropriate footwear...."<br><br>A fall circumstance, assessment and intervention form, dated 6/16/11, indicated at 10 p.m. the resident slid out of bed onto his knees. The "prevention update" was "resident education." (The resident had severe cognitive impairment as indicated on the admission MDS.)<br><br>An incident/accident investigation for the fall on 6/16/11, indicated the previous pertinent intervention was "bed alarm." The new intervention was "encourage resident to ask for help when he wants out of bed...."<br><br>A fall circumstance, assessment and intervention form, dated 7/4/11, indicated at 6:15 a.m., the resident was assisted to the floor in the resident's bathroom. The form indicated the resident had improper or ill fitting footwear. The "Prevention Update" indicated "Nonskid footwear."<br><br>An incident/accident investigation for the fall on 7/4/11, indicated "...Resident was being transferred to toilet et (and) was lowered to the floor c (with) staff help. When writer investigated, resident was sitting on the floor in front of toilet. Resident said his legs won't straighten. Loose fitting socks S (without) shoes | | | |

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| | observed...New intervention: Non skid stockings or shoes while being transferred." The resident was to have on appropriate footwear per the care plan, dated 5/15/11.<br><br>An incident/accident investigation for a fall on 7/11/11, indicated "...Resident observed sitting on floor in dinning (sic) room bathroom c (with) legs drawn up w/c (wheelchair) next to him. Bathroom call light on resident yelling help...Resident stated he was standing to go to the bathroom. The new intervention was will add clip alarm to wheelchair..." The form indicated the new intervention of "toilet resident q (every) 2 o (hours)" was crossed out.<br><br>A fall circumstance, assessment and intervention form, dated 8/15/11, indicated at 6:40 a.m., the resident was found on the floor in his room. The form indicated the resident was transferring himself and ambulating when he fell. The form indicated the prevention update was bed and/or chair alarm...." The fall circumstance, dated 6/16/11, indicated a bed alarm was already in place and the chair alarm had been added as an intervention on 7/11/11.<br><br>During an interview on 8/22/11 at 1:35 p.m., the corporate nurse consultant | | | |

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| | indicated the resident should have had on proper footwear when the fall occurred on 7/4/11. She indicated encouraging a resident to ask for assistance was not an appropriate intervention for a resident with cognitive impairment. The nurse consultant indicated the bed alarm had already been in place back in June.<br><br>This federal tag relates to Complaint IN00094788.<br><br>3.1-45(a)(2)<br><br>. | | | |
| F0514<br>SS=D | The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br>Based on observation, record review, and interview, the facility failed to ensure a resident's record was complete and accurate related to assessments and an | F0514 | 1. Facility completed investigation on Resident B and notified ISDH at the time of survey. There was no negative outcome noted.2. All residents are at risk for alleged | 09/23/2011 |

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| | investigation for injuries of unknown origin for 1 of 4 residents reviewed for injuries of unknown origin in a total sample of 4. (Resident B)<br><br>Findings include:<br><br>Resident B's record was reviewed on 8/19/11 at 12:45 p.m. Resident B's diagnoses included, but were not limited to, dementia, hypertension and anemia.<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 8/5/11, indicated the resident had severe cognitive impairment.<br><br>An accident/incident report, dated 8/16/11 at 7:00 a.m., indicated "...the resident was found with bruising to nose, sides of mouth, lip tear...Describe Injury...skin tear and bruise small in size (indicated by being circled)...Additional Information Resident was seen with redness to nose tip, both sides of mouth and lip with skin tear very agitated." The Incident/Accident investigation was left blank.<br><br>Resident B was observed on initial tour with LPN #1 on 8/19/11 at 8:50 a.m., sitting in his wheelchair in the dining room. There was a scabbed area to the resident's lower lip on the left side and a bruise that was yellow in color to the resident's face next to his mouth. The tip | | deficiency. Investigations for incidents of unknown origin will be reviewed for thoroughness and appropriate notification to ISDH by DHS or designee. Additional investigating and/or reporting will be completed accordingly.3. DHS or designee will in-service nurses on investigation procedures per facility policy and state reportable guidelines. Nurses will be required to notify the Administrator or designee of situations requiring an incident report.4. DHS or designee will review investigations within 24 hours of the incident and report to ISDH accordingly. Trends will be brought to monthly QA x 6 months or until 100% compliance is achieved. | |

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| | of the resident's nose was brownish red in color. LPN #1 indicated the resident had bitten his lip and the yellow bruise to the resident's face was new.<br><br>A "Change in Condition Form" dated 8/16/11, indicated "...7:15 a...Resident was seen with tip of nose reddish/bruised both sides of mouth with red marks, lip reddish skin tear and extremely aggitated (sic)..." The follow up assessments for 8/16/11 for the 3-11 shift and 8/16/11 for the 11-7 shift were blank and lacked assessments. The last documentation of an assessment was dated 8/18/11 on the 7-3 shift. There was a lack of documentation of an assessment for the 11-7 shift on 8/17/11 and for the 3-11 and 11-7 shifts on 8/18/11.<br><br>During an interview on 8/19/11 at 1:24 p.m., RN #2 indicated an investigation was supposed to be done by the nurse on 8/16/11 when the injuries were found. She indicated she had seen the yellow bruise on the resident's face when she had worked on Wednesday 8/17/11.<br><br>During an interview on 8/19/11 at 1:55 p.m., the Director of Nurses (DON) indicated she would have to check with LPN #1 for the investigation. She indicated the investigation should have been on the incident report. | | | |

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| | Resident B was observed on 8/19/11 at 2:10 p.m., with LPN #1 present. LPN #1 measured the areas to the resident's lip, nose, and bruise to left side of face by his mouth. The area to the resident's nose was 1.8 centimeters by 1.7 centimeters and was reddish/brown in color. The resident's left cheek bruise measured 4.6 by 1.7 centimeters and was yellow/green color. The resident's left lower lip scab was 3.2 by 0.2 centimeters. LPN #1 indicated he had started the investigation of how the areas occurred, but he had documented in a note book and he was unable to find the note book.<br><br>This federal tag relates to Complaint IN00094788.<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | | |